Health Information Technology Policy Committee
Final Summary of the August 19, 2010, Meeting

KEY TOPICS

1. Call to Order

Judy Sparrow welcomed participants to the 15th meeting of the Health Information Technology Policy Committee (HITPC), which took place virtually. She reminded the group that this was a Federal Advisory Committee meeting, and was being conducted with the opportunity for public comment. She conducted roll call, and turned the meeting over to HITPC Vice Chair Paul Tang.

2. Review of the Agenda

Paul Tang reviewed the day's agenda, and then asked for and received approval from the last HITPC meeting (held on July 21, 2010).

> **Action Item #1:** Minutes from the July 21, 2010, HITPC meeting were approved by consensus.

3. Report on Population Health Hearing

George Hripcsak presented this report on Art Davidson's behalf. On July 29, the HITPC Meaningful Use Workgroup convened a hearing on the topic of population and public health. One of the first tasks was defining population and public health. This is a broad term, and one that encompasses what this group is trying to achieve in meaningful use (i.e., not just health for individual patients, but health across the population).

The hearing included the following three panels:

- Achieving population health through meaningful use: How do governmental public health agencies view the process to date?

- Experiences and current status of meaningful use-like projects: How do governmental public health agencies use meaningful use-like criteria or measures to achieve population health?

- Potential areas for HITPC consideration: Where should the Committee focus its attention to support meaningful use measures and criteria that complement the public health mission?

George Hripcsak summarized the key findings and suggestions received at the hearing, as follows:

- The concept of "one health" was discussed—it is all linked, including clinical care, personal wellness, and public health.

- Meaningful use criteria may include:
  - A "send-it-to-public-health" button for case reporting
  - Dashboards for providers including quality indicators, preventive care status, and environmental factors
  - Clinical decision support that includes information from public health
  - Reporting the ability to download immunization data.

- The concept of a population health record (PopHR) that informs health workers and clinicians about local disease rates was introduced.

- Bidirectional flow of information (e.g., for immunization) is critical.

- There is a need for national data standards, especially the use of continuity of care documents (CCD) as a common medium and use of LOINC for laboratories.

- How to create a truly longitudinal record, including clinical care, vital records, and care delivered from within public health departments requires additional consideration.

- Occupation should be considered as a key variable to assess risk.

- The importance of addressing privacy (maintaining public trust) and patient identification (e.g., newborn screening ID) was discussed.

- The vision is for a next-generation health system that pulls together personal health records and public health.

The Meaningful Use Workgroup is now reviewing testimony and discussions from the hearing to formulate a set of proposed criteria for Stage 2.

In the brief discussion that followed, Michael Klag noted that the term "one health" is often used to describe emerging diseases and the link between animal health and human health. The American Veterinary Medical Association (AVMA) has a One Health initiative, and as the Workgroup moves forward, another term may be better suited to describe this concept.

4. Report on Care Coordination Hearing

David Bates explained that at the Meaningful Use Workgroup's Care Coordination Hearing, three panels were featured in the areas of current support of care coordination by HIT, transition in care coordination and related issues, and care coordination in the ambulatory environment. He provided the following overall assessment of the current status of care coordination, based on discussions and testimony at the hearing:

- Electronic health records (EHRs) of today do not support many of the key needs of practices, especially those focusing on enabling team care.

- There is tremendous evolution underway today in how these processes are being managed.

- Some best practices are going unreported.

- Many minor issues with the EHRs of today that can be addressed in the near term, but this is an area in which additional change will occur.

The key functions or critical domains and activities of EHRs for care coordination include reconciling medications, tracking lab tests, communicating across settings, and mediating care plans between disciplines. Several overarching recommendations were developed at the hearing. David Bates presented these recommendations, with the caveat that they are initial findings only:

- Include the ability to support an interactive and longitudinal care plan.

- Track who is on a care team, and share the information with the patient
  - Display and record for all patients who the primary care physician is and share this with the patient
  - Aggregate data or messages and send to all who need them.

- Support medication reconciliation, including at least four functions: (1) importing medication data from other sources, (2) displaying and comparing medication lists, (3) ordering medications, and (4) documenting that information.

- Transfer Summary Document—ensure that 9-11 elements from the Care Transitions Performance Set are included in transition recommendations (at least for discharges)
  - Not only provide the summary, but include the ability to confirm receipt
  - Include advanced care directives.

A number of specific recommendations also were presented at the hearing. These include: (1) supporting longitudinal views for issues such as admissions, including discharge diagnosis; (2) supporting the ability of multiple providers on a team to write notes and document simultaneously; (3) supporting the ability to designate who ordered the medication and who is allowed to refill it; (4) ensuring that referrals include the question to the consultant; (5) making problems lists sortable and searchable; and (6) making the medication list sortable by organ system.

The committee's discussion included the following points:

- David Lansky noted that in this and other hearings, much is being learned about the specific functions that would improve care coordination, such as how the medication list should be sorted. This is the type of issue that likely should not be proscribed to vendors, because this is something that one would expect the market to innovate and improve upon. It is important is to distill out those things that are the quality and safety enabling functions at an almost generic level that should be incorporated in as a criterion for meaningful use or as a quality measure. Medication error avoidance is an example. He asked Committee members to

consider what these higher-level metrics are that can be used to drive continuous improvement in the provision of EHRs.

- Gayle Harrell reiterated the need to keep specialists in mind. Most of what was discussed applies more to internal medicine, general medicine, and public health departments. However, they must remember that, with meaningful use, they want everyone to have EHRs from all of their providers. She urged the group to make sure that specialists are not left out of the realm of EHRs.

- Charles Kennedy expressed support for the notion of a shared care plan. He worries that if recommendations stay at too high a level, it may create some issues. For instance, where might that shared care plan sit? It is challenging to envision how multiple electronic medical records (EMRs) all operating independently could share a care plan, versus having it held centrally at a health information exchange.

- Neil Calman explained that shared coordination around patients is a critical issue, but simply the issue of how to get information from one point to another is where the field is at this point. There is not even a general model for what a care coordination plan looks like that is accepted on paper or that is used broadly. There is a need to become very granular about what specific recommendations should be made. The Committee should focus on concepts that represent real opportunity to improve patient safety or quality of care.

- Paul Tang summarized the discussion by indicating that there are some areas in which functionality does not currently exist and that in the context of this program—meaningful use incentives—these areas must be covered by the 2013 and 2015 criteria. The ONC can have other phases in the future, but this group should have very concrete and granular criteria to define what needs to be done in the shorter term.

- Neil Calman pointed out that there is a first-order approach to coordinated care in real integrated systems, where the majority of prescriptions are filled in the same place and where most of the people that a patient sees are working for the same organization. Bringing this kind of coordination up to the next level where those caregivers are all working in independent practices in different locations is a different endeavor. He suggested that Committee members first examine the systems that are substantially integrated and where the issues of health information exchange do not complicate matters. Then, they can see if there are some good models that could be brought to the next level.

- Christine Bechtel expressed concern about putting too much emphasis on 2015 because the incentive money in 2015 is negligible compared to earlier years. Consideration is needed for ways that the HITPC can be realistic about capabilities but also drive progress forward. She pointed to some quality measures around the documentation of the presence of a care plan that are endorsed by the National Quality Forum. The HITPC should consider what the key elements of the care plan are, what standards might exist, and whether the HIT Standards Committee (HITSC) might need to do some work in this area as well.

- Paul Tang explained that this information will be used in the Committee's September 22 meeting when it starts working on the drafts for the 2013 and 2015 objectives and criteria. The longer-term plan is to issue a Request for Information (RFI) towards the end of this calendar year so that the public has more opportunity to provide comment. All of this information, as well as feedback from the 2011 phase one processes, will be used to develop a final recommendation to the Committee for endorsement next spring, in preparation for stage two criteria.

5. Privacy and Security Tiger Team

Privacy and Security Tiger Team Chair Deven McGraw and Co-Chair Paul Egerman presented a letter to the Committee for consideration, to be forwarded on to the National Coordinator. The 18-page letter represents a culmination of the team's work over the summer. Deven McGraw began noted that the Committee has already reviewed many of the recommendations offered in the draft letter.

The presentation covered the team's core, overarching recommendations, in particular those addressing: (1) patient consent; (2) triggers in meaningful consent and the extent to which they distinguish directed exchange and the circumstances in which they recommend that patients' meaningful consent be obtained for health information exchange; (3) granular consent and in particular, the view from a technology standpoint with respect to the ability of EHR technology to support patient consent at a more granular level; and (4) some concluding remarks.

Deven McGraw then presented a series of slides to illustrate the team's concepts and recommendations, some of which have been reviewed by the Committee previously. Paul Egerman presented the set of recommendations dealing with consent and directed exchange. Again, this material was, for the most part, presented previously but has been modified to address comments from this Committee and from the HITSC.

Recommendation 3.1 deals with consent and directed exchange. Assuming fair information practices (FIPs) are followed, directed exchange does not create an additional requirement for patient consent, beyond what may already be required in law.

Recommendation 3.2 discusses situations in which consent is required, and does not involve directed exchange. Rather, it involves other exchange processes that are possibly more complicated. When this information was presented at a prior Committee meeting, there were six different triggers presented, which caused confusion. The team was able to simplify this into a single trigger. The revised recommendation now reads as follows:

- When the decision to disclose or exchange the patient's identifiable health information from the provider's record is not in the control of the provider or that provider's organized health care arrangement (OHCA), patients should be able to exercise meaningful consent to their participation.

Paul Egerman presented some examples of when such a situation might arise, and discussed what might happen when patients do not give consent.

Deven McGraw then discussed the attributes of "meaningful consent," pointing to language in the recommendation letter and in the appendix of the slide deck. Paul Egerman discussed the team's recommendations on consent implementation guidance. He noted that they are suggesting that the federal government, through the ONC, has a role to play in educating the consumer about issues of consent. Ultimately, it is the provider's responsibility to educate and administer the consent for their patients. However, a variety of other entities should be working together to reduce the burden on the providers.

Deven McGraw reiterated the team's recommendation that providers should have a choice about participating in exchange models.

Paul Egerman discussed the issue of more granular patient consent, which deals with the ability of a patient to decide to share some, but not all, of their data. The team held a technology hearing on June 29 in order to learn what technology currently exists that allow patients to make such granular determinations. They also worked with the National Committee on Vital and Health Statistics (NCVHS) to make sure their work was in accordance with NCVHS recommendations. The Tiger Team learned that there is some promising technology, but much of it is still in early stages of development and adoption. They recommend that the ONC should make it a priority to stimulate innovation in this area, and to carry out some piloting and examine models in operation before it moves towards wider adoption.

In discussion, the following points were made:

- Neil Calman noted that, he has a choice about how he runs his practice in every possible way except that, according to these recommendations, he would still have to take care of a patient who does not want to be part of an exchange that aggregates information—even though his practice is a part of this type of exchange. He could not say to a patient, "If you come to my practice, this is the way we do business. If you don't want your information handled or aggregated in this way, this is what happens in our practice." He suggested that the team rethink this scenario.

- Neil Calman indicated that his concern is that they do not want to do anything that discourages providers from using electronic means to facilitate communication. He is concerned that they will be required to participate in this consenting process and then be told, "Not only do you have to do that, but you have to potentially have two ways of delivering this." He understands that they are not requiring two ways, but in reality that is what is being signaled. He suggested working with regional exchanges and taking advantage of those things that require some value added, and he will come to depend on those as things that provide safety and improved quality for his patients. However, he will also have to have a mechanism to carry out exactly those same functions if his patients choose not to include their information in the exchange.

- Christine Bechtel noted that if a patient does not want his or her data shared in a trigger situation because the provider loses control, and she decides she does not want to consent, she does not think that is cause to be removed from the practice.

- Paul Egerman acknowledged that this is a debate that does not have a natural resolution. On one hand, from a health care standpoint, people would say that exchange is good for patients. On the other hand, those who are concerned about individual autonomy will say that patients have the right to control the flow of their own data. The conversation that might take place between a provider and a patient who has privacy concerns may well end up with the patient consenting to data sharing 99 percent of the time—but it would be a real conversation, with meaningful consent.

- Given the concerns expressed from the health care providers' perspective regarding recommendation 3.2, Judy Faulkner suggested that the Committee is taking a risk in not being more clear as to whether there is some burden being placed on providers.

- Joy Pritts read the definition of an OHCA so that the group could understand who was being included and who was being excluded in directed exchange.

- The group discussed the distinction between Health Information Organizations (HIOs) and OHCAs, and acknowledged that the distinction between the two was not as clear as previously thought.

- Paul Tang noted that some of the definitions, particularly of HIOs, are not at all set in concrete. There is a Nationwide Health Information Network Workgroup examining the governance issues; much of this discussion is interrelated.

> **Action Item #2:** The Committee unanimously accepted the Privacy and Security Tiger Team letter of recommendation, and will forward it to the National Coordinator.

6. Enrollment Workgroup Update

Enrollment Workgroup Co-Chair Sam Karp noted that the Workgroup has developed 10 recommendations based on the work of four tiger teams as well as the National Information Exchange Model (NIEM) work that was conducted by the ONC. Given the timeline constraints in the statutes and the time required for the federal clearance process, the Workgroup asked for Committee approval of these recommendations at this meeting, although there may be minor changes still to be made.

He presented the recommendations, explaining that the Workgroup envisions the final document to be 3-5 pages in length, prefaced with a preamble about the importance of consumer usability and consumer mediation, which is consistent with the Affordability Care Act and focused on making enrollment much more efficient and consumer friendly. Also included will be a series of appendices with much more detailed information that supports each of the 10 recommendations.

Sam Karp discussed the Workgroup's first three recommendations having to do with core data and verification.

- Recommendation 1.1: We recommend that federal and state entities administering health and human services programs use the NIEM guidelines to develop, disseminate, and support the standards and processes that enable the consistent, transparent exchange of data elements between programs and states.

The Workgroup is not recommending or even suggesting that states should change their core data elements or the way they collect and display those data elements within their own systems. Through this recommendation, it is suggesting that the data elements that are known to be common across many programs can be transmitted between programs, so that the receiving program is able to identify and incorporate the data element into its system.

The committee discussed this recommendation, bringing up these points:

- Gayle Harrell asked if the Workgroup is suggesting that an interface be built that connects all of these disparate databases. Workgroup member Doug Fridsma explained that the reason for the recommendation to use the NIEM process is that it provides a standard to which those programs can be mapped rather than trying to map all of them. As new systems are constructed, they can then follow those standards to assure interoperability.

- In response to a question about whether mapping to this standard is a requirement or merely a recommendation, Farzad Mostashari indicated that the work of the HITPC and HITSC as well as ONC in making these recommendations is focused on the standards. It is not centered around what policy should be used with respect to how states implement the various enrollment eligibility programs that are envisioned as part of the Affordable Care Act (ACA).

Sam Karp then discussed two verification interface recommendations, as follows:

- Recommendation 2.1: We recommend that federal agencies required by Section 1411 of the ACA share data with states and other entities for verification of an individual's initial eligibility, re-certification, and change in circumstances for health insurance coverage options under the ACA, use a web service approach that could also be used to support such eligibility determinations in other health and human services programs, including Medicaid, CHIP, SNAP and TANF.

- Recommendation 2.2: We recommend development of a federal reference implementation tool, containing standards for obtaining verification of an individual's eligibility information from federal agencies, to ensure a consistent, cost-effective, and streamlined approach across programs, states, and community partners. The initial build of this tool should include interfaces to the federal agencies included in Recommendation 2.1. In order to ensure comprehensive and timely verification, additional interfaces to other federal, national or widely-available data sources and tools should be added, including the National Directory of New Hires, the Electronic Verification of Vital Events Record (EVVE) system, State Income and Eligibility Verification (IEVS) systems, Public Assistance Reporting Information System (PARIS), and the U.S. Postal Service Address Standardization API tool.

The Committee had questions about the policy implications of these technological decisions they were being asked to make. Workgroup Chair Aneesh Chopra explained such conversations are being led by the Secretary's office in conjunction with the White House Office of Health Reform.

Aneesh Chopra then discussed the remaining recommendations, which relate to business rules, transmission of enrollment information, and privacy and security:

- Recommendation 3.1: federal and state agencies should express business rules using a consistent, technology neutral standard (e.g., SBVR, WC3's RIF, etc.). Upon identification of a consistent standard, federal and state agencies should clearly and unambiguously express their business rules (outside of transactional systems) to provide maximum transparency to the consumer.

- Recommendation 3.2: To allow for the open and collaborative exchange of information and innovation, we recommend that the federal government maintain repository of business rules needed to administer ACA and Medicaid health insurance programs, which may include an open source forum for documenting and displaying eligibility, entitlement and enrollment business rules to the public in a standards-based format.

- Recommendation 4.1: We recommend using existing Health Insurance Portability and Accountability Act (HIPAA) standards (e.g., 834, 270, 271) to facilitate transfer of applicant eligibility, enrollment, and disenrollment information between ACA health insurance programs, health and human service programs, and public/private health plans.

- Recommendation 4.2: We recommend developing new standards to acknowledge a health plan's receipt of an HIPAA 834 transaction.

- Recommendation 5.1: We recommend that consumers have: (1) timely, electronic access to their eligibility and enrollment data in a format they can use and reuse; (2) control over the appropriate uses of such data, including sharing across programs to facilitate additional enrollments; and (3) the ability to correct and/or update such data upon request to the program.

- Recommendation 5.2: We recommend that the consumers' ability to designate proxy (e.g., third party) access be as specific as feasible regarding authorization to data (e.g., read-only, write-only, read/write, or read/write/edit), access to data types, access to functions, role permissions, and ability to further designate proxies. If proxy access is allowed, access should be:
  - Subject to the granting of separate authentication and/or login processes for proxies;
  - Tracked in immutable audit logs designating each specific proxy access and major activities; and
  - Time-limited and easily revocable.

- Recommendation 5.3: We recommend that state or other entities administering health and human services programs implement strong security safeguards to ensure the privacy and

security of personally identifiable information. Specifically, we recommend the following safeguards:

- Data in motion should be encrypted. Valid encryption processes for data in motion are those which comply, as appropriate, with NIST SP 800-52, 800-77, or 800-113, or others which are Federal Information Processing Standards (FIPS) 140-2 validated.
- Automated eligibility systems should have the capability to:
  - Record actions related to the PII provided for determining eligibility. The date, time, client identification, and user identification must be recorded when electronic eligibility information is created, modified, deleted, or printed; and an indication of which action(s) occurred must also be recorded.
  - Generate an audit log—enable a user to generate an audit log for a specific time period and to sort entries in the audit log.

In discussion, the following points were made:

- Gayle Harrell suggested that the language in the recommendations regarding business rules extend beyond standards-based formats to suggest human readable formatting as well.

- Deven McGraw suggested that there be a limitation of use agreements among the participating agencies, to indicate the sentiment that they are using this data to determine eligibility and that is the only use of the information.

- Paul Egerman suggested that, in Appendix E, where it reads "collection and limitation," it could instead read as "collection and use limitation," and that would address the issue.

Action Item #3: The Committee unanimously accepted the Enrollment Workgroup's set of recommendations, with the following two line edits:

1. Language describing standards-based formats should suggest human readable formatting as well.
2. In Appendix E, "collection and limitation" should instead be "collection and use limitation."

7. Information Exchange Workgroup

Information Exchange Workgroup Chair Micky Tripathi reminded the group that the Information Exchange Workgroup has been refocused and has developed some new task forces and an agenda. A new list of workgroup members, which includes David Lansky as Co-Chair, was presented. The group now has more representation in the areas of Medicaid and public health.

The Workgroup is going to focus on breakthrough areas in which there are policy barriers that may be preventing providers and/or states from being effective enablers of broader and deeper health exchange. Those are specific clinical transactions that are already identified as important or critical issues that are likely to get unearthed as this effort progresses with all of the various activities underway related to information exchange at every level.

The group intends to be a conduit for state-level activities. Many of the challenges that result in policy issues are not obvious from the beginning, and they often emerge from implementation activities. This Workgroup will be able to distill issues as they arise and as they appear in a number of places that are policy relevant and may lend themselves to actionable policy solutions.

David Lansky described the two new subgroups that have formed within the Information Exchange Workgroup: one will work on issues related to interoperability among provider directories, while the other looks at public health topics, including meaningful use public health reporting and daily exchange requirements.

At the next HITPC meeting, the Workgroup will present a detailed work plan and deliverables for each of the task forces, as well as some discussion about what might be the next set of focus areas. It will be important to coordinate with other Workgroups to track their focus on stage two and three meaningful use definitions and support these efforts. For the October HITPC meeting, the Workgroup hopes to present recommendations on provider directories and some perspectives on key public health issues that could be in the form of recommendations. They will coordinate with the Meaningful Use workgroup on this topic.

8. Public Comment

There were no public comments made during the meeting.

SUMMARY OF ACTION ITEMS:

Action Item #1: Minutes from the July 21, 2010, HITPC meeting were approved by consensus.

Action Item #2: The Committee unanimously accepted the Privacy and Security Tiger Team letter of recommendation, and will forward it to the National Coordinator.

Action Item #3: The committee unanimously accepted the Enrollment Workgroup's set of recommendations, with the following two line edits:

- Language describing standards-based formats should suggest human readable formatting as well.
- In Appendix E, "collection and limitation" should instead read as "collection and use limitation."